PEDIATRIC PARTNERS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (Print Patient's Full Name)

_____ Birth date (Mo/Day/Year)

_____ (Street Address)

_____ Social Security Number

_____ (City, State, Zip Code)

_____ Home Phone

At the request of the individual, I_____ (Patient/Parent name) do hereby authorize _____ (Name of Facility)

____DISCHARGE SUMMARY
____HISTORY & PHYSICAL
____PROGRESS NOTES
____PATHOLOGY REPORTS
____LABORATORY REPORTS
____RADIOLOGY REPORTS
____EMERGENCY REPORTS
____OTHER _____

From the time period of _____ to _____.

____I do ____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____ Street address
Pediatric Partners
Suite 104
5816 Creedmoor Road
_____ City, State, Zip
Raleigh, NC 27612
(919) 787-9555
FAX **(919) 510-5111**

_____ Phone Number _____ Fax Number

PURPOSE OF DISCLOSURE:
____REFERRAL TO SPECIALIST ____INSURANCE ____CHANGE OF DOCTOR ____WORKERS COMP
____LEGAL INVESTIGATION ____DISABILITY DETERMINATION ____CONTINUING CARE
____PERSONAL ____OTHER (Specify)_____

Please provide current daytime telephone number in the event we need to contact you:

_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification or cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

SIGNATURE OF INDIVIDAL OR GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE **DATE**